COLORADO
Department of Regulatory Agencies
Division of Insurance

October 17, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Assistant Secretary Lisa M. Gomez
Employee Benefits Security Administration
Department of Labor

Commissioner Danny Werfel
Internal Revenue Service
Department of the Treasury

RE: Colorado Division of Insurance Supports Proposed Requirements Related to the Mental Health Parity and Addiction Equity Act

Dear Administrator Brooks-LaSure, Assistant Secretary Gomez, and Commissioner Werfel,

The Colorado Division of Insurance (the Division), which regulates the commercial insurance industry in Colorado, writes to express its support for and offer comments regarding the Departments' of the Treasury, Labor and Health and Human Services (the Departments) proposed requirements related to the Mental Health Parity Addiction Equity Act (MHPAEA) published in the Federal Register on August 3, 2023.

Background

In 2019, the Colorado legislature passed HB 19-1269, the Behavioral Health Care Coverage Modernization Act, which addressed issues related to mental health parity and coverage of mental health, behavioral health, and substance use disorder (SUD) services, and it provided the Division with additional capacity to enforce MHPAEA in state-regulated plans. The Division then promulgated Colorado Insurance Regulation 4-2-64 - Concerning Mental Health Parity in Health Benefit Plans, specifying carrier coverage, reporting, and communication requirements for state mental health parity laws. Carriers submit and the Division reviews annually the following quantitative treatment limitation (QTL) and non-quantitative treatment limitation (NQTL) data:

- Financial requirements compliance;
- Medical management policies and standards;
- Network adequacy, including reimbursement rates, contracting, and negotiations processes;
- Network admission, including credentialing processes, denials, approvals, and timeline;
- In- and out-of-network utilization, as substantiated by claims, and denial rationales;
- Utilization management standards, processes, and practices, including step therapy, prior authorization, and concurrent review;
- Appeals processes, including the process and makeup of carrier review panels; and
- Comparative analyses.

The Division welcomes the opportunity to comment on the Departments' proposed changes related to MHPAEA and offers insight based on its enforcement strategy and action.

Division Responses to the Departments' Proposed Regulatory Changes

Classification of Mental Health/SUD Benefits

The Departments' amendment to clarify definitions of medical/surgical, mental health, and SUD benefits as it pertains to QTL and NQTL benefit coverage, including:

- Any condition or disorder defined by the plan or coverage as being or not being a mental health condition or a SUD must be defined to be consistent with generally recognized independent standards of current medical practice. Specifically, the plan's or coverage's definition of "mental health benefits" must include all conditions covered under the plan or coverage, except for SUDs that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Statistical Classification of Diseases and Related Health Problems (ICD) or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- The plan's or coverage's definition of "SUDs" must include all disorders covered under the plan or coverage that fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD or that are listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the DSM.

Division Response:

The Division strongly supports this change, as it is consistent with Colorado's definitions. Specifically, Colorado Revised Statutes Section 10-16-104(5.5), states that "behavioral health, mental health, and [SUD]" means a condition or disorder, regardless of etiology, that may be a result of a combination of genetic and environmental factors that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of the ICD, DSM, The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) and includes autism spectrum disorders (ASD).

In addition to improving clarity on best practices and aligning enforcement standards across regulating authorities, this change will ensure that coverage for ASD, eating disorders, gender dysphoria, and other conditions will be no more restrictive or costly than coverage for other physical health conditions. The Division also encourages the Departments to specify the DC:05 in its clarification of generally recognized independent standards.

Definitions of "Restrictive" and "Treatment Limitation"

The Departments provide further clarification of the definitions of both "restrictive" and "treatment limitation." They specify that an NQTL is restrictive if it imposes conditions, terms, or requirements that limit access to benefits under the terms of the plan or coverage, and would include, but would not be limited to, those that compel an action by or on behalf of a participant or beneficiary (including by their authorized representative or a provider or facility) to access benefits and those that limit access to the full range of treatment options available for a condition or disorder under the plan or coverage. They also amend the definition of "treatment limitation" to include and clarify a non-exhaustive, illustrative list of NQTLs.

Division Response:

The Division strongly supports these clarified definitions as it improves understanding of potential compliance or non-compliance.

Explicit Application of Predominant/Substantially All Testing to NQTLs
The Departments clarify that plans and issuers are required to follow similar steps for NQTLs to those that apply when analyzing the predominant and substantially all tests to financial requirements and QTLs under the 2013 final regulations. These steps involve determining the portion of plan payments for medical/surgical benefits subject to an NQTL in a classification; whether the NQTL applies to substantially all medical/surgical benefits in the classification; the predominant variation of the NQTL that applies to medical/surgical benefits in the classification; and whether the NQTL, as applied to mental health and SUD benefits in the classification, is more restrictive than the predominant variation of the NQTL as applied to substantially all medical/surgical benefits.

Division Response:
The Division appreciates the additional clarity on the formulaic approach to the predominant and substantially all testing to NQTLs, although it encourages the Departments to expand the data used in that predominant and substantially all test beyond projected claims payments. Claims payments - projected or retrospective - only illustrate the experience of people that actually access covered benefits by providers that are in the network. Data like network admission approvals and denials, provider-carrier contract negotiation and completion, and rates of post-payment audits are other examples of evidence that inhibit providers' participation in networks and thus directly or indirectly impact consumers' ability to use their insurance for necessary behavioral health services. It is also not clear how this analysis includes the policies "as written" in a projected claims payment calculation, and it does not include approval and denial data regarding utilization management protocols, like step therapy, prior authorization, or concurrent review practices that may inhibit care.

While the included illustrative list of NQTLs provide helpful insight - specifically regarding discriminatory non-coverage of behavioral health conditions - the Division welcomes additional guidance from the Departments on a formulaic NQTL assessment outside of projected or retrospective claims payments to encompass other common parity issues "as written" and "in operation."

Outcome Data
The Departments state that a plan or issuer must collect and evaluate relevant data in a manner reasonably designed to assess the impact of a NQTL on access to mental health and substance use disorder benefits and medical/surgical benefits, and consider the impact as part of the plan's or issuer's analysis of whether such NQTL, in operation, complies with parity requirements. The relevant data must include, but is not limited to, the number and percentage of relevant claims denials, as well as any other data relevant to the NQTLs as required by State law or private accreditation standards. The Departments also state that plans and issuers must collect and evaluate data related to network composition, including but not be limited to, in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates (including as compared to billed charges).

Division Response:
The Division supports the data collection change, as it aligns with requirements in Colorado Insurance Regulation 4-2-64 Concerning Mental Health Parity in Health Benefit Plans, and it improves clarity on best practices to better align enforcement standards across regulating authorities. However, the Division requests additional information from the Departments regarding the definition, analysis, and standards to measure what constitutes "material," as the ratio, percentage, and/or concrete number may vary across enforcement entities, plans, and issuers. The Division also encourages the Departments to require plans and issuers to collect data on the rationales for denials for consumer care and provider network admission.

Comparative Analysis Reporting
The Departments propose to codify comparative analysis reporting and content requirements, and it specifies four (4) areas, at minimum, that must be included in the analyses: out-of-network utilization, percentage of in-network providers actively submitting claims, time and distance standards, and reimbursement rates.

Division Response:
The Division strongly supports this change and appreciates the addition of four (4) minimum standards for inclusion. It encourages the Departments to include and clarify the additional data points and definitions for the following topic areas in order to illustrate more completely carrier practices for network admission and adequacy:

- The total numbers of providers by license type in-network and the number of providers by license type submitting claims;
- A definition of "actively submitting claims" and metrics associated;
- The number of in-network providers by license type that have submitted claims in the last year; and
- Network admission/credentialing timelines, approvals, denials, rationales for such, and accreditation standards.

Safe Harbor
The Departments intend to create an enforcement safe harbor with respect to NQTLs related to network composition for plans and issuers that meet or exceed specific data-based standards identified in future guidance. Plans and issuers that satisfy the terms of the safe harbor would not be subject to an enforcement action by the Departments under MHPAEA with respect to NQTLs related to network composition for a period of time.

Division Response:
The Division is concerned with the proposed enforcement strategy. While it appreciates that state regulating authorities like the Division are not required to implement a safe harbor for carriers indicating compliance, it has concerns with the Departments' implementation of this as it may negatively impact consumers. A two-year safe harbor for a plan or issuer may create significant barriers to care for consumers by eliminating enforcement of reimbursement rates, out-of-network utilization, claims processing, and other network composition standards. Further, parity compliance metrics that may change within a two-year timeframe. The Division also strongly encourages the Departments to clarify the standard by which plans and issuers may be granted a safe harbor, including documentation, evidence, and verification by the regulating authority above and beyond a plan or issuer's self-attested comparative analysis.

Fraud, Waste, and Abuse
The Departments propose an exception to the NQTL no more restrictive requirements that are reasonably designed to detect or prevent, and prove fraud, waste, and abuse that have been reliably established through objective and unbiased data.

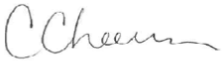
Division Response:
While the Division agrees with the Departments on the importance of reducing costs to the health care delivery system overall, it is important that reliance on fraud, waste, and abuse mitigation not become a utilization management tool to limit care and access to behavioral health or SUD services. This may arise in particular when enforcing parity-compliant coverage for prescription drugs. For example, quantity limits are often reportedly used to mitigate fraud, waste, and abuse for drugs used

in medication-assisted treatment (MAT) for substance use disorder (SUD) or medications to treat opioid use disorder (MOUD). These limits create barriers to care and limit provider capability to respond to patient needs, made more necessary due to changes in drug potency due to the presence of fentanyl and xylazine.

Further, the tactics to investigate and/or reduce fraud, waste, and abuse can disproportionately impact mental health and SUD providers, and it is important to not increase administrative burden for these providers that does not occur for medical/surgical providers and to further disincentivize mental health and SUD providers from participating in commercial insurance networks.

The Division extends its gratitude to the Departments for its review of MHPAEA and its proposed changes, and it looks forward to working with the Departments, other state regulators, and plans and issuers in its implementation.

Sincerely,



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